PRINTED: 10/19/2011
FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN7506 | A. BUILDING 02 - STATE BUILDING<br>B. WING _____ | 10/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NORTHSIDE HEALTH CARE CENTER | 202 EAST MTCS ROAD<br>MURFREESBORO, TN 37130 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| N 002 | 1200-8-6 No Deficiencies<br><br>Based on observations during the survey on 10/17/11 at 9:50 AM, revealed no fire safety deficiencies. | N 002 | | |

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Alexandra R. Callahan

TITLE: Administrator

(X6) DATE: 11/3/11